AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: May 6, 2016/Amended June 8, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Removal and replacement intrathecal narcotic pump

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is a Board Certified Anesthesiologist with over 14 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XX/XX/XX: Spin Echo T1 and T2. Impression: 1. Laminectomies at L4-5 and L5-S1 with no MR evidence of residual or recurrent disk herniation. 2. Mild Intervertebral disk degeneration and bulging lateralizing mildly to the left at L4-5 and L5-S1 is seen with slight flattening of the anterior thecal sac greater on the left at these levels. No appreciable mass effect on the nerve root sleeves.

XX/XX/XX: Lumbar Spine X-ray. Impression: 1. Status post implantation of prosthetic device at L5-S1. 2. Spondylolisthesis, Grade I, L5 on S1. 3. Disc narrowing, L4-5. An underlying herniated disc cannot be ruled out.

XX/XX/XX: Follow Up Visit. CC: program pain pump PTM at 0.250mg bringing total daily dose to 10.538 mg per day. Her reservoir reads 7.7cc and she is scheduled for pump refill on X/XX/XXXX. PE: palpation tenderness to midline, paralumbar, buttocks, ROM moderately decreased. DX: displacement of lumbar intervertebral disc, chronic pain syndrome, spasm of muscle, chronic post-surgical pain, lumbar radiculopathy, disc stenosis of intervertebral foramina of lumbar region, backache NOS, neuritis. Plan: take all medications as prescribed, continue PT, use TENS unit 3-4 times per day, in-office pump refill.

XX/XX/XX: Procedure Note. Preoperative Diagnosis: Chronic pain syndrome. Postop Diagnosis: Chronic pain syndrome.

XX/XX/XX: Follow up Office Visit. CC: complaining of low back pain, and refill her intrathecal narcotic pump. 2cc of old

medication removed and refilled her pump with Dilaudid and increased the dosage to 10mg per day with the ability to get 3 boluses per day of 0.3 mg of Dilaudid per bolus. DX: chronic pain syndrome. Plan: take off all medications as prescribed, in office pump refill/maintenance, f/u in 10 weeks.

XX/XX/XX: Follow up Office Visit. CC: LBP due to failed back surgery. Removed 3.4 cc of old medication which was within the expected limits and refilled with same medication and dosage. DX: chronic pain syndrome, chronic post-surgical pain, backache NOS, thoracic or lumbosacral neuritis or radiculitis, unspecified. Plan: no prescriptions, in office refill/maintenance, f/u in 11 weeks.

XX/XX/XX: UR. Reason for denial: This review results in the following determination regarding the treatment being requested: Adverse Determination. If peer to peer contact was made for this case, a summary of the contact information is supplied below.

XX/XX/XX: Letter of Recommendation. Please reconsider my request for replacement of the claimant's intrathecal pump reservoir. The original reason for denial was explained as there was not an expiration date of the pump. The expected pump expiration date will be 3 months. Since her expiration date is so close, please give approval for replacement of her intrathecal pump.

XX/XX/XX: UR. Reason for denial: A previous determination indicated the request was non-certified, given the submitted records did not indicate the elective replacement indicator alarm had any indications that the pump was due for replacement. The life span of the most recent pain pump had not been documented. The documentation submitted for review indicated the claimant had an intrathecal narcotic pain pump. It was noted the last pump printout would be provided, which showed an expected expiration date in 3 months. However, no additional documents were received. Therefore, given the submitted records did not indicate the elective replacement indicator alarm had any indications that the pump was due for replacement, and the lifespan of the most recent pain pump had not been documented, the request is not supported. Peer to peer discussion has not been achieved despite a call to the MD's office. Given the above, the request for reconsideration removal and replacement intrathecal narcotic pump is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld and agreed upon. The submitted records did not indicate the elective replacement indicator alarm had any indications that the pump was due for replacement. The life span of the most recent pain pump had not been documented. The documentation submitted for review indicated the claimant had an intrathecal narcotic pain pump. It was noted the last pump printout would be provided, which showed an expected expiration date in 3 months. However, no additional documents were received. Therefore, given the submitted records did not indicate the elective replacement indicator alarm had any indications that the pump was due for replacement, and the lifespan of the most recent pain pump had not been documented, the request for Removal and replacement intrathecal narcotic pump is not supported and denied.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**